STATE DISCIPLINE OF PHARMACISTS

OFFICE OF INSPECTOR GENERAL

OFFICE OF EVALUATION AND INSPECTIONS

JULY 1990

STATE DISCIPLINE OF PHARMACISTS

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OAI-01-89-89020

JULY 1990

EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to assess the disciplinary practices of State boards of pharmacy. It examined the strengths and vulnerabilities of the pharmacy boards in attempting to ensure that pharmacy is practiced safely, competently, and in accordance with pharmacy and drug laws.

BACKGROUND

This is the sixth in a series of Office of Inspector General (OIG) reports on State boards of licensure and discipline. The other reports have focused on boards of medicine, dentistry, podiatry, chiropractic and optometry. In this, as in the other reports, the OIG's interest in the boards' performance is based on the important front line of protection they afford to the public. The inquiry was based on: (1) telephone discussions with representatives from all the State boards of pharmacy, (2) visits to six States for in-depth discussions with board representatives, (3) discussions with representatives from State and national professional organizations and government agencies, and (4) review of pertinent literature and data.

FINDINGS

The enforcement responsibilities of State pharmacy boards have become increasingly complex and challenging in recent years because of changes in pharmacy practice and the problem of drug diversion.

Many States have taken important steps to strengthen the enforcement capacity of State pharmacy boards.

- Many States have broadened their regulatory and disciplinary controls through changes in their pharmacy and drug laws.

- Many States have strengthened the boards' capacity to address drug diversion.

The number of the most serious types of disciplinary actions taken by State pharmacy boards between 1986 and 1988 increased for the nation as a whole. However, virtually all this increase occurred in three States, and the incidence of serious disciplinary actions varied considerably among the States.

- For the nation as a whole, the most serious types of disciplinary actions taken by State pharmacy boards between 1986 and 1988 increased by slightly more than 20 percent. These actions include revocations, suspensions, probations, and voluntary surrenders of licenses.

- Most of the increase in the most serious disciplinary actions between 1986 and 1988 is attributable to three States. Many pharmacy boards took relatively few such actions during this period.

- Rates of the most serious disciplinary action taken by State pharmacy boards during this period varied widely—from 1.49 actions per 1000 licensees in one State to 45.61 actions per 1000 licensees in another.

- In most States, as in the nation as a whole, the number of revocations and voluntary surrenders did not increase between 1986 and 1988.

- The limited use of peer review by many professional pharmacy associations, particularly in comparison with that in some other professions, makes the disciplinary performance of pharmacy boards all the more significant.

Pharmacy boards impose the most serious discipline mainly for drug diversion and self-abuse of drugs. They rarely address quality of care issues, despite the increasing emphasis in the profession on the clinical aspects of pharmacy practice.

The ability of many State pharmacy boards to protect the public is hampered by limitations in their legal authorities, administrative processes, and resources.

RECOMMENDATIONS

The State Governments

- State governments should ensure that State pharmacy boards have adequate resources and authority for carrying out their enforcement responsibilities effectively.

- State governments should take steps to streamline the administrative process so that State pharmacy boards are able to process disciplinary cases more efficiently.

- State governments should take steps which enhance the capacity of pharmacy boards to deal with drug diversion and impairment of pharmacists.

State Pharmacy Boards

- State pharmacy boards should review the outcomes of their disciplinary process and evaluate whether they are affording the public the maximum protection possible.

- State pharmacy boards should disseminate more broadly information on the disciplinary actions they have taken.

The National Association Of Boards Of Pharmacy

- The National Association of Boards of Pharmacy (NABP) should intensify its efforts to help State pharmacy boards address the changing nature of pharmacy practice, particularly with respect to the clinical roles of pharmacists.

- The NABP should work with State pharmacy boards and national professional pharmacy organizations to explore viable approaches to assessing the continued competence of licensed pharmacists.

The American Pharmaceutical Association

- The American Pharmaceutical Association (APhA) should exercise its leadership in encouraging more peer review of pharmacists' professional performance by national and State professional pharmacy organizations.

- The APhA should work with the NABP and other professional pharmacy organizations to develop appropriate methods for assessing the continued competence of pharmacists.

The U.S. Public Health Service

- The Public Health Service (PHS) should increase its support to the NABP in its efforts to provide leadership to State pharmacy boards.

COMMENTS

Comments on the draft report were received from the Health Care Financing Administration and the Public Health Service within the Department, and from the Drug Enforcement Administration of the Department of Justice. These comments were in general agreement with the findings and recommendations of the report. Comments were also received from several national organizations including the American Association of Colleges of Pharmacy (AACP), American Pharmaceutical Association (APhA), American Society of Hospital Pharmacists (ASHP), National Association of Boards of Pharmacy (NABP), and the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR). These organizations, too, were generally supportive of our recommendations, although the APhA and the NABP expressed some reservations about our recommendation calling for more peer review of pharmacists' professional performance by national and State professional pharmacy organizations. A summary of these comments and our response to issues raised appear at the end of the report. The detailed comments appear in appendix A.

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INTRODUCTION

The purpose of this inspection was to assess the disciplinary practices of State boards of pharmacy. It examined the strengths and vulnerabilities of the pharmacy boards in attempting to ensure that pharmacy is practiced safely, competently, and in accordance with pharmacy and drug laws. Specific attention was focussed on the disciplinary authorities of pharmacy boards, on their processes for enforcement and discipline, and on the extent, type, and reasons for their disciplinary actions in recent years.

This report is the sixth in a series of reports issued since 1986 by the Office of Inspector General (OIG) on the various State health professional boards: medicine, dentistry, podiatry, chiropractic, and optometry.

The Federal Government has long recognized the paramount role played by State regulatory boards in setting the standards for the licensure and discipline of health care practitioners. In so doing, it has relied on the States to provide an important front line of protection for the health and safety of the public. In particular, the Department of Health and Human Services (HHS) has relied on State boards to provide overall assurance that the health care services supported by the Medicare and Medicaid programs are provided by health care professionals duly licensed and practicing within the terms of the States' practice acts and other related laws. Although the Department can sanction providers who have abused or defrauded these programs, it continues to depend upon State boards to discipline providers for transgressions unrelated to the Medicare or Medicaid programs.

As expenditures under the Medicare and Medicaid programs have grown to be larger than one-fourth of all expenditures for health care in the United States, the Department's interest in the performance of State regulatory boards for the various health professions has increased. In this context, a report on the performance of State pharmacy boards, particularly in fulfilling their disciplinary responsibilities, is both relevant and timely. For many years, nearly all States have reimbursed pharmacists for services provided to Medicaid recipients. It is possible, too, that Federal health care benefits will be expanded during the 1990s in which case the relevance of the State boards of pharmacy to the Department may become even greater.

The information for this inspection was based on four lines of inquiry: (1) telephone discussions with the chief executives of the State pharmacy boards during the spring of 1988 and the spring of 1989; (2) visits to six States (CA, FL, MA, MI, NY, TX) involving discussions with several pharmacy board representatives; (3) review of pertinent literature and relevant data bases; and (4) discussions with representatives of various major professional associations concerned with disciplinary practices of pharmacy boards. (For more methodological background, see appendix C.)

This report presents our findings on the practices of State pharmacy boards in disciplining pharmacists. It begins with a brief profile description of State boards of pharmacy. It then

turns to a discussion of the disciplinary practices of the boards and concludes with recommendations for action addressed primarily to State governments and State boards of pharmacy.

STATE BOARDS OF PHARMACY

Pharmacy boards, like other health professional boards, are administrative agencies created by State governments to protect the health, welfare, and safety of the public through the regulation of pharmacy practice.[1] State governments have empowered pharmacy boards to establish the scope of pharmacy practice, to license pharmacists and pharmacies, and to discipline those who violate the legal requirements. In the United States today, approximately 183,000 pharmacists are in active practice in nearly 68,000 pharmacies.[2]

From their early days in the late 1800s, pharmacy boards, like the other health professional boards, were primarily examining boards which emphasized their licensure activities more than their discipline function. They were relatively inconspicuous agencies of State government which functioned largely autonomously and were comprised solely of pharmacists.

Since the 1960s, the environment has changed considerably for State professional boards. With the consumer movement and heightened concern about the quality of health care services, more attention has been focussed on the performance of boards in protecting the public. Demands for greater accountability led many States to bring professional boards into large central agencies, to add public members to complement the professionals, and to place more emphasis on discipline.

Pharmacy boards have, however, developed into entities which vary significantly from other health professional boards. Pharmacy boards do more than define the scope of professional practice and license and discipline the professionals. They also regulate pharmacies as the facilities in which the profession is practiced, and they regulate the distribution of the drug product itself. Thus the purview of pharmacy boards is much broader and in some ways their task is more complex than that of other health professional boards.

Pharmacy boards, too, vary significantly among themselves. Boards differ in the scope of their responsibilities. For many boards these responsibilities extend beyond the practice act and the licensure and discipline of pharmacists and pharmacies. Seventy-five percent of the boards, for example, also license and inspect drug manufacturers and wholesalers.[3] Nearly forty percent of the boards are the State scheduling authorities for controlled substances.[4] Finally, many pharmacy boards have significant responsibilities in administering their States' food and drug laws.[5]

Pharmacy boards differ in the way they are organized. About 50 percent of the pharmacy boards report that they are attached to a larger government department and are not independent. Some boards have sole authority to make rules and regulations; some do not. Most boards, but not all, can both license and discipline. A few boards are advisory to other

entities of State government who make final decisions about rules, licenses, and discipline concerning pharmacy. Pharmacy boards have an average of seven members, although they range from three to 21 members. Seventy percent of the boards have at least one public member. In most States, board members are appointed by the Governor for terms ranging from 3 to 6 years.

Pharmacy boards also vary in the staff and other resources which support them. Although the large majority of boards have full-time directors, a few do not employ directors or have only part-time directors. The number of staff available to boards ranges from one State having one part-time person to another State having 31 staff. These data, however, do not always include the inspectors and investigators available to the boards. Finally, annual board budgets among the reporting 39 States range from a low of $2,500 in one State to a high of $2,874,104 in another State.[6]

This widespread variation among the pharmacy boards makes generalizations about them difficult. What boards do and how they do it depend in large part on their responsibilities, organization, and resources. Nonetheless, we believe that our inquiry has yielded important understandings about the strengths and vulnerabilities of the boards as they discipline pharmacists—understandings which are pertinent to most pharmacy boards today.

FINDINGS

The enforcement responsibilities of State pharmacy boards have become increasingly complex and challenging in recent years because of changes in pharmacy practice and the problem of drug diversion.

The practice of pharmacy has been undergoing significant and rapid change since World War II. Pharmacy boards, as regulators of pharmacy practice, face a challenging task in keeping up with the complex changes in drug therapies, distribution systems and practice settings, and pharmacists' professional roles and responsibilities.

Rapid technological changes have resulted in the explosive proliferation of new drug products and the development of sophisticated drug therapies and delivery systems. Computerization has affected not only the routine administrative aspects of pharmacy practice such as labeling and record keeping but has enabled various more sophisticated applications such as robotics, fax machines for transmitting prescriptions, and automated drug profiles for more complete monitoring of patients' drug therapies.

Pharmacy practice has also been affected by the concerns of consumers and third-party payers, both public and private, over the rapidly increasing costs of health care. Economic factors have contributed significantly to the emergence of mail order pharmacies as well as drug repackaging companies which are encouraging the dispensing of prescription drugs by physicians and other health care professionals. Cost containment efforts by private insurers and the Federal Government have resulted in greater emphasis on shorter hospital stays and increased reliance on outpatient care. As a result, pharmacy is being practiced more and more in settings other than community pharmacies and hospitals. Practice in nursing homes, ambulatory care facilities, and patients' homes, for example, may require different regulatory approaches by pharmacy boards.

The role of the pharmacist, too, has been experiencing significant change. No longer is the pharmacist primarily the compounder of medicines now that drug products are developed and manufactured by pharmaceutical companies. Gradually, an additional role for pharmacists as therapeutic advisors has been evolving.[7] The nation's pharmacy schools have revised curricula and degree programs to incorporate clinical training to address this new role. And the national standards for pharmacy practice developed by the American Pharmaceutical Association (APhA) and the American Association of Colleges of Pharmacy (AACP) in 1979 clearly articulated clinical responsibilities for practicing pharmacists.[8] The challenge to pharmacy boards has been, and continues to be, whether and how best to translate these clinical expectations into the States' regulatory requirements governing the practice of pharmacy.[9]

Finally, pharmacy boards have had to cope with the changing regulatory responsibilities imposed on them by the Federal Government. Recent Federal initiatives which significantly affect the regulatory and enforcement efforts of State pharmacy boards include tighter controls

over controlled substances, State licensure of wholesale prescription drug distributors, and the new national practitioner data bank.

According to one pharmacy board official, all these changes in pharmacy practice have been "progressing faster than the boards of pharmacy's ability to regulate that practice." [10] Indeed, keeping up with the rapidly changing face of pharmacy was identified recently by pharmacy board executives as the major challenge facing pharmacy boards today.[11]

In addition to the dramatic changes occurring in pharmacy practice, the serious national problem of drug diversion has complicated the enforcement responsibilities of State pharmacy boards. For several years, the diversion of prescription drugs from legitimate distribution channels for illicit use has been most acute at the retail level—practitioners and pharmacies. More than 10 years ago, the General Accounting Office (GAO) estimated that over 200 million dosage units of prescription drugs were being diverted each year at the retail level. More recently, the Drug Enforcement Administration (DEA) has estimated that 80 to 90 percent of the prescription drugs diverted for non-medical use is occurring at the practitioner and pharmacy levels.[12]

Diversion of controlled substances at the pharmacy level occurs in several ways. It can result from direct illegal sales of controlled substances by pharmacists or from outright theft of drugs from pharmacies, either by pharmacists for their own use or by others. Diversion can also result from prescription forms which are counterfeit or have been stolen or altered in some way. And finally, a more subtle form of diversion can occur when pharmacists, either knowingly or unknowingly, dispense controlled substances which have not been issued for legitimate medical purposes. This practice, often referred to as "non-therapeutic dispensing", can involve controlled substances being dispensed to addicts or to the public for other unapproved clinical indications or for further distribution.[13]

Many States have taken important steps to strengthen the enforcement capacity of State pharmacy boards.

- Many States have broadened their regulatory and disciplinary controls through changes in their pharmacy and drug laws.

Pharmacy is often described as the most highly regulated of all health professions. In recent years, many State legislatures and pharmacy boards have been moving to address the changes occurring in pharmacy by further expanding their regulatory control. Slightly more than two-thirds of the States, for example, have separate regulations governing the practice of pharmacy in institutional settings or requiring computerized storage of prescription records. Nearly one-half have regulations governing nuclear pharmacies where radioactive drugs and devices are handled. A growing number of States now require pharmacists to keep patient profile records and to provide counseling to their patients.[14] Controversial regulatory issues such as the use of pharmacy technicians, mail order pharmacies, and the dispensing of

prescription drugs by health professionals other than pharmacists are currently under debate in many States.

The National Association of Boards of Pharmacy (NABP) has provided important leadership to States in their efforts to stay abreast of the rapid changes in pharmacy practice. In 1977, the NABP developed a Model State Pharmacy Act as well as model regulations for institutional pharmacy, nuclear pharmacy, and pharmacy computerization to serve as guidelines to State boards. Over the last 3 years alone, the NABP has developed guidelines and model laws or regulations on issues such as wholesale drug distribution, anabolic steroids, use of sterile pharmaceuticals in home health care, mail order pharmacies, patient counseling, and impaired pharmacists.

During the past 3 or 4 years, at least one-fourth of the States have also been strengthening their boards' authority to discipline pharmacists.[15] At present, every board reported having authority to revoke and suspend licenses and most, but not all, have authority to place licensees on probation or to deny the renewal of licenses. However, only approximately two-thirds of the boards have authority to impose fines for violations, and only about one-third of the boards reported having written guidelines for their use in deciding which penalties to impose.

Disciplinary penalties may be imposed by pharmacy boards only for reasons (or grounds) specified in the States' pharmacy practice acts. These grounds vary somewhat from State to State. However, the majority of States have adopted those grounds recommended in the NABP Model Act. These include unprofessional conduct; incapacity which prevents a pharmacist from practicing with reasonable skill, competence and safety to the public; court convictions for acts involving gross immorality or moral turpitude; fraud, deceit, or misrepresentation; and violations of State and Federal pharmacy or drug laws.[16]

- Many States have strengthened the boards' capacity to address drug diversion.

Nine States have now adopted a multiple copy prescription program which enables State authorities, including pharmacy boards, to monitor the distribution of Schedule II controlled substances from the prescriber to the dispenser to the consumer. The experience of several States suggests that these programs can result in a 30 to 50 percent reduction in Schedule II prescriptions. They have been effective in combatting problems with forged prescriptions and in reducing theft of controlled substances from pharmacies. These programs, too, have enhanced the efficiency of State regulators, including pharmacy board inspectors and other law enforcement personnel, by facilitating their review of prescription data through aggregated reports as opposed to the time-consuming review of individual scripts on site.[17]

Nearly half the States have adopted requirements for separate registration of all practitioners, including pharmacists, who handle controlled substances. This registration is different from the pharmacist's license to practice and separate from the DEA registration which is issued to the pharmacy rather than the pharmacist. Such a registration can be used by the boards to

restrict or deny the pharmacist's privileges to dispense controlled substances while still retaining the basic privilege to practice. The registration can also be a source of additional revenues for investigating drug diversion.[18]

Finally, several States have established Task Forces of local, State, and sometimes Federal agencies concerned with drug diversion to improve coordination and communication among them.

In efforts such as these, many States have recognized the critical and unique role which can be played by pharmacy boards in combatting drug diversion by pharmacists and pharmacies. Among all the agencies combatting drug diversion, only the pharmacy boards have the legal authority to revoke the licenses of pharmacists and pharmacies and thereby to terminate their legal rights to practice.

The number of the most serious types of disciplinary actions taken by State pharmacy boards between 1986 and 1988 increased for the nation as a whole. However, virtually all this increase occurred in three States, and the incidence of serious disciplinary actions varied considerably among the States.

- For the nation as a whole, the most serious types of disciplinary actions taken by State pharmacy boards between 1986 and 1988 increased by slightly more than 20 percent. These actions include revocations, suspensions, probations, and voluntary surrenders of licenses.

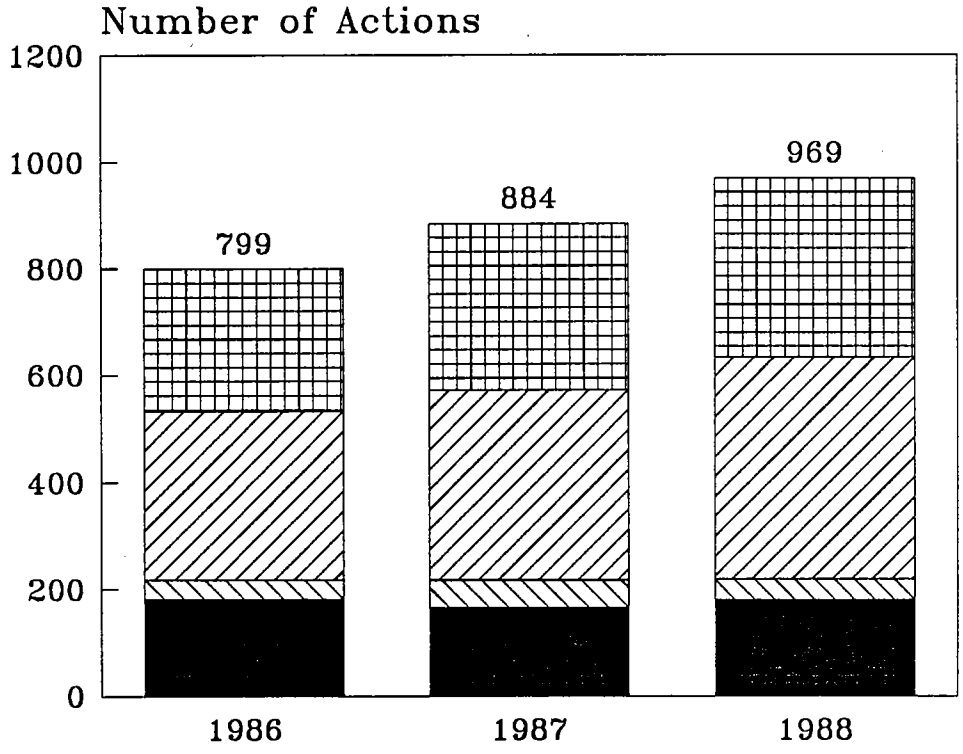
Because comprehensive disciplinary data was not available from any existing sources, we asked the board executives in all 50 States plus the District of Columbia to provide us with information on the number and type of serious disciplinary actions taken by their boards in 1986, 1987, and 1988. We received information for all 3 years from all but four States. Nevada and New York were unable to provide data for all 3 years. Oklahoma provided data only for revocations, and Kentucky provided no data for 1988. (See appendix B for a state-by-state breakdown of serious disciplinary actions reported for the period 1986-1988 and appendix C for a more detailed description of our methodology.)

We found that the number of the most serious disciplinary actions—revocations, suspensions, probations, and voluntary surrenders—imposed by pharmacy boards on pharmacists and pharmacies increased by slightly more than 20 percent during this 3-year period. These actions increased from 799 in 1986 to 969 in 1988.[19] Suspensions accounted for nearly 60 percent of this increase and were approximately 40 percent of all the most serious actions imposed during this period (see figure I).

As noted earlier, pharmacy boards also take other kinds of formal disciplinary actions such as reprimands and fines. These other kinds of penalties are important disciplinary tools and can be used effectively by boards. We did not include these other types of actions in our analysis

Figure I

Serious State Disciplinary Actions Against Pharmacists and Pharmacies, 1986–1988



	1986	1987	1988
Probations	266	312	336
Suspensions	315	355	414
Vol. Surrenders	36	51	38
Revocations	182	166	181

Source: 49 State Boards of Pharmacy as reported to the Office of Inspector General, HHS, May 1989.

summarized here. This is not because we considered them unimportant, but because we considered the data available to us on these actions too imprecise for reliable analysis.[20]

- Most of the increase in the most serious disciplinary actions between 1986 and 1988 is attributable to three States. Many pharmacy boards took relatively few such actions during this period.

About 97 percent of the overall increase in the most serious disciplinary actions resulted from the actions of three States. In fact, one State alone accounts for 57 percent of this increase.

Our analysis indicates that many pharmacy boards imposed these most serious penalties infrequently during the 3-year period between 1986 and 1988. The median rate of discipline among the States was approximately eight of these most serious actions per 1000 licensees during this time[21]. Further, 15 States reported taking 10 or fewer of these most serious actions during this entire period. In fact, seven States reported fewer than 5 such actions. All these States were those we categorized as small or extra-small except for one medium-sized State. Seven States, all small or extra-small, took no serious actions at all for one of these 3 years. (See appendix C for a more detailed description of our typology.)

- Rates of the most serious disciplinary action taken by State pharmacy boards during this period varied widely—from 1.49 actions per 1000 licensees in one State to 45.61 actions per 1000 licensees in another.

In addition, considerable variation is also apparent when disciplinary actions are correlated with location and size. States in the Midwest disciplined at the highest rate of 15.55 actions per 1000 licensees—nearly twice as often as those in the West and nearly three times as often as those in the Northeast. The large States disciplined most frequently—at a rate of 15.57 actions per 1000 licensees. This rate was more than one and one-half times the rate of the extra-small and the extra-large States, both of which disciplined least frequently and at nearly equal rates.

How are we to account for these wide variations in the performance of the boards? Perhaps some boards are more committed to aggressive discipline than others. It could be that those boards with fewer actions are dealing with more complicated cases or resolving informally types of cases which other boards might bring to hearings. Finally, these variations might result to some degree from differences in the administrative process or in the resources available to the boards. It is likely that each of these factors to some extent affects the disciplinary performance of the boards.

- In most States, as in the nation as a whole, the number of revocations and voluntary surrenders did not increase between 1986 and 1988.

Revocations and voluntary surrenders of licenses are the most serious of all disciplinary penalties imposed by the boards. Yet we found that the use of these penalties did not change much overall and accounted for only 25 percent of all the serious actions taken during the entire period.

We think it is important to note, too, that the number of revocations summarized here may overstate the severity of the boards' disciplinary activity. Although revocations are the ultimate penalty available to boards, they are often neither as permanent nor as serious as the public may think. Boards can, for instance, reinstate the licenses they once revoked. In fact, at least 243 licenses were reinstated in 1987.[22] Boards also may impose revocations, only to stay them and effect a lesser penalty. The boards reported to us only the most serious penalty for those actions involving multiple penalties. Thus our data on the number of revocations does not reflect the actions actually effected.

We recognize also that the disciplinary practices of State pharmacy boards encompass significant activity which is not captured through analysis of the most serious disciplinary actions they impose. As we shall see, the majority of complaints and problems are handled by administrative staff through a variety of informal interventions. Nevertheless, we think serious disciplinary actions are an important indicator of the rigor of pharmacy boards in fulfilling their responsibilities to the public.

- The limited use of peer review by many professional pharmacy associations, particularly in comparison with that in some other professions, makes the disciplinary performance of pharmacy boards all the more significant.

We found that the APhA and most State professional associations of pharmacists have been largely inactive in monitoring the performance of their members in recent years. The APhA as well as some State professional associations have formalized processes in their bylaws for review of their members' conduct. However, fears of antitrust litigation have dampened the peer review efforts of most associations with which we had contact. Peer review by professional associations has been less limited in other professions such as medicine, dentistry, and podiatry.

To be sure, the performance of pharmacists is monitored to some extent by other government agencies. The States' Medicaid Fraud Control Units as well as the DEA and other State agencies with responsibilities for controlled substances laws can punish wrongdoing by pharmacists. The Office of Inspector General can exclude pharmacists and pharmacies from participation in the Medicare and Medicaid programs. Data from our case study States showed that these pharmacy boards had, for the most part, imposed serious disciplinary penalties against those pharmacists and pharmacies sanctioned by the OIG between 1984 and 1988.[23]

Nonetheless, perhaps to a greater extent than other health regulatory boards, pharmacy boards are the primary protectors of the public in relation to the practice of their licensees. Other

mechanisms useful in monitoring the performance of other health professionals, such as mandatory reporting laws and hospital peer review committees, are not as prominent in monitoring the performance of pharmacists.

Pharmacy boards impose the most serious discipline mainly for drug diversion and self-abuse of drugs. They rarely address quality of care issues, despite the increasing emphasis in the profession on the clinical aspects of pharmacy practice.

Approximately half of all the formal disciplinary actions reported to us by pharmacy board executives for the period 1986-1988 were for reasons of diversion and impairment. These officials estimated that nearly one-fourth of these actions were the result of diversion by the pharmacist for economic gain; nearly three-fourths of them primarily for impairment of the pharmacists due to self-abuse of drugs. Analysis of the those disciplinary actions reported to the NABP's Disciplinary Clearinghouse confirmed these reports. Slightly more than half the violations reported to the Clearinghouse for the years 1986, 1987, and 1988 involved drug diversion and self-abuse of drugs.

Drug Diversion

For many pharmacy boards, drug diversion cases consume considerable time and effort from both administrative staff and board members. Discussions with board officials in our case study States confirmed that drug diversion cases are among those having top priority for investigation and prosecution and for receiving the most severe disciplinary sanctions.

In identifying and developing drug diversion cases, pharmacy boards typically work with officials from local and State law enforcement agencies as well as from the DEA. Approximately two-thirds of the boards reportedly utilize the DEA's ARCOS reports to identify potential diversion.[24] However, less than 20 percent of the boards reported that they rely primarily on ARCOS, because its reports are considered too untimely and not always readily available to pharmacy inspectors. Most pharmacy boards identify potential diversion cases primarily through pharmacy inspections and from information received from other government agencies. Several boards reportedly have instituted their own systems for tracking the distribution of controlled substances by manufacturers and wholesalers.

In several States, the pharmacy boards have focussed particular attention on the problem of non-therapeutic dispensing by pharmacists. Federal controlled substances legislation allows prescribers to write prescriptions only for legitimate medical purposes in the usual course of their professional practice. The law defines a corresponding responsibility for pharmacists to fill only legitimate prescriptions and makes them accountable for the prescriptions they dispense.[25] The pharmacy boards in California, Michigan, and Texas, for example, have widely publicized the corresponding responsibility of pharmacists and have imposed discipline on those who violate these legal requirements.

Impairment

In recent years, many pharmacy boards have come to recognize the importance of therapeutic interventions when dealing with pharmacists impaired by the abuse of alcohol or other drugs. Although the extent of chemical dependence among pharmacists is not known for sure, the APhA has suggested that chemical dependency affects a "substantial" number of pharmacists and pharmacy students.[26]

With the leadership of organizations such as the AACP, APhA, and NABP and some State pharmacy associations and pharmacy boards, the number of education and treatment programs for impaired pharmacists has increased dramatically since the early 1980s. Approximately 80 percent of the States now have programs to assist impaired pharmacists. These programs are usually operated by the State pharmacy associations or by private, non-profit agencies under contract to State government agencies. The NABP has encouraged pharmacy boards to establish cooperative relationships with rehabilitation programs and to offer rehabilitation as either adjuncts or alternatives to formal discipline.

In five of our six case study States, the pharmacy boards had official connections with treatment programs. Three of the boards usually direct impaired pharmacists into these programs, sometimes in conjunction with action against the license but sometimes not. The other two pharmacy boards have had only one option when dealing with impaired pharmacists: mandatory revocation of license in one State; surrender of the license during treatment in the other. In both States, however, recent or pending legislation will grant the boards more latitude in the actions they can take. In all these States, impaired pharmacists who enter these programs voluntarily are not reported to the boards unless they are considered by program staff to be of danger to the public or drop out of the programs prematurely. Considerable variation exists among these boards in the extent to which they monitor the progress of pharmacists they have ordered into treatment and the degree to which they rely on the programs to determine when treatment has been completed successfully.

Quality of Care

With pharmacy boards devoting so much of their time and effort to problems of diversion, impairment, and technical violations, one might ask how much attention boards focus on pharmacists who may be incompetent. The answer is that boards seem to be doing very little either to identify pharmacists who may be incompetent or to ensure that practicing pharmacists have maintained at least minimal levels of competence.

During the 3-year period 1986-1988, the States reported to the NABP fewer than two dozen disciplinary actions for reasons they described as incompetence. Moreover, board representatives from our case study States reported that although their practice acts included incompetence as one grounds for discipline, their boards had rarely, if ever, disciplined pharmacists for incompetence.[27]